MISSOURI DEPARTMENT OF SOCIAL SERVICES
REHABILITATION SERVICES FOR THE BLIND

REFERRAL FOR SERVICES

NAME	SPOUSE OR PARENT (IF UNDER 21)
ADDRESS (STREET OR RR, CITY, ZIP CODE)	COUNTY
BIRTHDATE / SEX / MARITAL STATUS / TELEPHONE NUMBER	
EDUCATION	IS THIS A NEW REHABILITATION SERVICES REFERRAL? ☐ YES ☐ NO

FINANCIAL INFORMATION (IMPORTANT, COMPLETE ALL BLANKS)

INCOME SOURCE	AMOUNT	RECEIVED BY	SOCIAL SECURITY NUMBER
TOTAL MONTHLY INCOME AVAILABLE TO HOUSEHOLD ▶	GROSS	NET	NUMBER IN HOUSEHOLD

SAVINGS AND RESOURCES OTHER THAN HOME (SAVINGS ACCOUNTS, C.D.'S, DIVIDENDS, INVESTMENTS, TRUSTS, ETC.)

MEDICAL INSURANCE COVERAGE

A. PRIVATE INSURANCE, HOSPITAL	SURGICAL	B. TITLE XIX (MEDICAID) ☐ YES ☐ NO
NAME(S) OF OTHER AGENCIES PROVIDING SERVICES		MEDICAID CARD NUMBER
NAME(S) OF OTHER HOUSEHOLD MEMBERS RECEIVING SERVICES THROUGH REHABILITATION SERVICES FOR THE BLIND		MEDICARE **PART A** ☐ YES ☐ NO **PART B** ☐ YES ☐ NO

I REQUEST THAT MY EYE EXAMINATION APPOINTMENT BE SCHEDULED WITH (CHECK ONE)
☐ NO PREFERENCE ☐ OPHTHALMOLOGIST (M.D. OR D.O.) ☐ OPTOMETRIST

MEDICAL INFORMATION

HISTORY OF EYE CONDITION AS GIVEN BY APPLICANT

EYE CARE SPECIALIST NAME	ADDRESS
DATE OF LAST EXAM	DIAGNOSIS
DEGREE OF VISION ▶	W/OUT CORRECTION R.E. / L.E.
	WITH CORRECTION R.E. / L.E.

OTHER DISABILITIES

TRANSPORTATION
DO YOU USE THE O.A.T.S. OR S.M.T.S. BUS SERVICE? ☐ YES ☐ NO

SERVICE(S) NEEDED

APPLICATION FOR SERVICES

I hereby apply for services of Rehabilitation Services for the Blind. I authorize Rehabilitation Services for the Blind to obtain information from your records relative to my application. I certify that the above information is a true statement of my present financial status.

APPLICANT'S SIGNATURE	SOCIAL SECURITY NUMBER	DATE
REFERRED BY	TELEPHONE NUMBER	DATE

IS THIS A DIVISION OF FAMILY SERVICES OFFICE REFERRAL? ☐ YES ☐ NO